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I. Historical Perspective

The Children’s Hospital of Philadelphia was founded in 1855 as the nation’s first hospital devoted exclusively to the care of children. Children's Hospital is committed to improving the health of today's and tomorrow’s children through its clinical care programs, its basic and clinical research programs and training the next generation of pediatric healthcare professionals.

Children's Hospital provides comprehensive care, both inpatient and outpatient, for children from birth through age 19. With 304 medical and surgical beds, 20 percent of which are allocated to intensive care, and 45 beds in the Children’s Seashore House, the Hospital admits more than 20,000 inpatients and handles more than 950,000 emergency and outpatient visits annually.

Critically ill children and those suffering from unusual or hard to diagnose diseases are sent here from throughout the Delaware Valley, the nation and the world. Because of such specialized programs, Children's Hospital is consistently ranked among the top two of all pediatric hospitals in the United States in the physicians' rating of America's best hospitals in U.S.News & World Report. Children’s Hospital was rated first in three consecutive Child Magazine surveys.

Children's Hospital takes pride in its role as the community caregiver for the disadvantaged children of West and South Philadelphia. As a result of this commitment, the Hospital absorbs millions of dollars in uncompensated care each year.

The advancement of pediatrics through research and education is also central to the mission of Children's Hospital. In May 1995, the Hospital dedicated its state-of-the-art research facility. The 13-story Leonard and Madlyn Abramson Pediatric Research Center houses the Joseph Stokes Jr. Research Institute, which receives more than $150 million annually in research funding.

Research undertaken at the Hospital has resulted in many advances in the prevention, diagnosis and treatment of childhood disease, including the development of the isollet incubator, the first closed incubator for newborns; the cardiac balloon catheter technique for curing specific congenital heart defects in infants; and vaccines against rubella and mumps.

The Hospital is also known for its treatment and research into pediatric trauma. For the past 10 years, it has been certified as the only Level I Pediatric Trauma Unit serving southeastern Pennsylvania.

Each year, Children's Hospital's graduate medical training programs train more than 150 pediatric professionals in 26 different subspecialties, who then go on to careers in academic medicine, medical research or community practice. The Hospital is also a pediatric training ground for medical students from the Perelman School of Medicine at the University of Pennsylvania, for clinical and research fellows from universities worldwide, and for nursing students from eight schools of nursing.

Surgical care of the pediatric patient in the early years was erratic and morbid because of failure to recognize pathologic conditions, traumatic operative techniques and poor post-operative care.
Up until the 1940s, surgical care of the pediatric patient was performed by adult surgeons who usually demonstrated a fleeting interest in care of the child. With strong encouragement by I.S. Ravdin, then chairman of Surgery at the University of Pennsylvania, C. Everett Koop, MD, was sent to Boston for special training in surgery of the child under the direction of Robert Gross, MD. Dr. Koop returned from Boston to establish a surgical department at The Children’s Hospital of Philadelphia, assuming the role of surgeon-in-chief. The department flourished under his leadership and transformed the surgical care of pediatric patients indelibly.

A. **Research at The Children’s Hospital of Philadelphia**

The Hospital's Joseph Stokes Jr. Research Institute is home to one of the largest government and foundation supported pediatric research programs in the country. More than 600 projects are supported by more than $150 million in funding. With more than $100 million of this funding from the National Institutes of Health awards, Children's Hospital has the second largest NIH-sponsored research budget among U.S. pediatric hospitals.

Some of the many areas of research strength at Children's Hospital include the following:

- Investigating new ways of treating lung disease in premature infants
- Studying the genetic basis of a wide range of childhood illnesses, including abnormalities of the spine and childhood cancers
- New methods to treat birth defects through the development of new surgical techniques, fetal stem cell transplantation and gene therapy in conjunction with the Hospital’s Center for Fetal Diagnosis and Treatment
- Center for Injury Research and Prevention (formerly Traumalink), a program seeking to understand and prevent injury through a multidisciplinary approach combining the sciences of medicine, epidemiology and engineering

B. **Division of Orthopedic Surgery Description**

The Division of Orthopedics provides the full spectrum of musculoskeletal care:

**Spine conditions:** The division’s spine team has specialized expertise in spinal disorders of childhood and is internationally recognized for helping to increase understanding and for developing improved techniques

**Trauma:** The division has an exceptional depth of expertise in the surgical and non-surgical treatment of trauma-related injuries. The Children’s Hospital of Philadelphia is the only designated Level 1 Trauma Unit in southeastern Pennsylvania

Additional areas of specialized knowledge and care are:

- Pediatric sports medicine
- Hip disorders
- Foot and ankle disorders
- Leg-length discrepancy
- Hand and arm disorders
- Limb deficiencies and amputations
- Cerebral palsy, spina bifida and muscular dystrophy
- Metabolic diseases involving bone
- Circulatory disorders involving bone
- Connective tissue disorders
- Musculoskeletal infections
- Synovial disorders
- Complex limb deformity

Significant time and effort goes into clinical and basic science research for a variety of musculoskeletal conditions. The medical staff is very active in the development of new procedures, the presentation of research findings and publishing in peer reviewed journals.

C. Brief History of Orthopedics at CHOP and HUP

Orthopedic surgery at the Perelman School of Medicine at the University of Pennsylvania became a distinct discipline from general surgery in 1877, when Dr. DeForest Willard was named clinical professor of Orthopedic Surgery. Dr. Willard was instrumental in the development of the Orthopedic Hospital and Infirmary for Nervous Diseases at Penn, which was probably the most completely equipped specialty hospital in the country in 1850.

The Chairmen following Dr. Willard were as follows:
- Gwilyn C. Davis, M.D. (1911-20)
- Arthur Bruce Gill, M.D. (1920-42)
- Paul C. Colonna, M.D. (1942-1958)
- David Grice, M.D. (1958-60)
- Edgar L. Ralston, M.D. (1960-77)
- Carl T. Brighton, M.D. (1977-95)
- Scott Levin, M.D. (2009 – present)

With the help of the ladies auxiliary, Dr. DeForest Willard raised enough money to build a children’s ward. Charles Merril, MD, was the first pediatric orthopedist at The Children’s Hospital of Philadelphia. He was scheduled to become the first chief, but due to his untimely death, Jesse Nicholson, MD, became the chief of Orthopedics in 1936 and held the position until 1968.

The Chairmen following Dr. Nicholson were as follows:
- Stanley Chung, M.D. (1974-1979)
- Hugh Watts, M.D. (1979-1985)
- John P. Dormans, M.D. (1996-present)
D. Faculty and fellows of the Department of Orthopedic Surgery

Faculty

**Full-time:**
Keith D. Baldwin, MD, MPH, MSPT
Robert M. Campbell Jr, MD
Robert B. Carrigan, MD
Richard S. Davidson, MD
John P. Dormans, MD, FACS
Denis S. Drummond, MD
John M. Flynn, MD
Theodore J. Ganley, MD
Arlene Goodman, MD
Matthew Grady, MD
B. David Horn, MD
Helen Meeks Horstmann, MD
John T. Lawrence, MD, PhD
Christina Master, MD
Wudbhav N. Sankar, MD
David A. Spiegel, MD
Lawrence Wells, MD
Jennifer Winell, MD

**Part-time:**
Benjamin Chang, MD
Malcolm L. Ecker, MD
Bong S. Lee, MD

Fellows (since 1988)

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<thead>
<tr>
<th>Year</th>
<th>Name</th>
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<tbody>
<tr>
<td>1988-89</td>
<td>Michael Albert, MD</td>
</tr>
<tr>
<td>1990-91</td>
<td>Gary Brock, MD</td>
</tr>
<tr>
<td>1992-93</td>
<td>Wesley Carrion, MD</td>
</tr>
<tr>
<td>1994-95</td>
<td>Miah Hahn, MD</td>
</tr>
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<td>1996-97</td>
<td>Theodore Ganley, MD</td>
</tr>
<tr>
<td>1998-99</td>
<td>David Wallach, MD</td>
</tr>
<tr>
<td>2000-01</td>
<td>Kristan Pierz, MD</td>
</tr>
<tr>
<td>2002-03</td>
<td>Benjamin Royle, MD</td>
</tr>
<tr>
<td>2003-04</td>
<td>Michelle Sugiyama-Caird, MD</td>
</tr>
<tr>
<td>2005-06</td>
<td>Josh Strassberg, MD</td>
</tr>
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<td>2007-08</td>
<td>Purushottam A. Gholve, MD</td>
</tr>
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<td>2009-10</td>
<td>Colin Goggins, MD</td>
</tr>
<tr>
<td>2011-12</td>
<td>Keith Baldwin, MD</td>
</tr>
<tr>
<td></td>
<td>Omohodion Binitie, MD</td>
</tr>
<tr>
<td></td>
<td>Corinna Franklin, MD</td>
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<tr>
<td>1989-90</td>
<td>Lee Segal, MD</td>
</tr>
<tr>
<td>1991-92</td>
<td>William Bronson, MD</td>
</tr>
<tr>
<td>1993-94</td>
<td>Mark Sinclair, MD</td>
</tr>
<tr>
<td>1995-96</td>
<td>Inez Kelleher, MD</td>
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<tr>
<td>1997-98</td>
<td>David Spiegel, MD</td>
</tr>
<tr>
<td>1999-2000</td>
<td>Lael Luedtke, MD</td>
</tr>
<tr>
<td>2001-02</td>
<td>Junichi Tamai, MD</td>
</tr>
<tr>
<td>2004-05</td>
<td>Jorge Fabregas, MD</td>
</tr>
<tr>
<td>2006-07</td>
<td>Samara Friedman, MD</td>
</tr>
<tr>
<td>2008-09</td>
<td>Jason Robison, MD</td>
</tr>
<tr>
<td>2010-11</td>
<td>Todd Lawrence, MD</td>
</tr>
<tr>
<td>2012-13</td>
<td>Laura Gill, MBBS</td>
</tr>
<tr>
<td></td>
<td>Sean P. Kearney, MD</td>
</tr>
<tr>
<td></td>
<td>Martin Morrison, III, MD</td>
</tr>
<tr>
<td></td>
<td>Nanjundappa</td>
</tr>
<tr>
<td></td>
<td>Harshavardhana, MD</td>
</tr>
</tbody>
</table>
II. **Introduction**

**A. The Children’s Hospital of Philadelphia: House Staff Supervision Policy**

The faculty works with the residents on a daily basis making careful observation of each individual's strengths and weaknesses. Thus, each faculty member can implement strategies to help a resident reach his or her potential as an orthopedic surgeon. The faculty members of the Department of Orthopedic Surgery have defined objectives for each of the five years of clinical education. The objectives are accumulative and focus upon the fundamental principles of developing a sound cognitive basis of the musculoskeletal system over the subsequent four years. As the residents are assigned services, such as CHOP, they assume increasing responsibility in the outpatient, inpatient, operative and emergency situations as described above. Working with members of the faculty permits assessment of each resident's abilities and allows the faculty member to focus upon the educational needs and technical advancement of each resident.

While on this service, students and residents will become familiar with the theory and details of the management of pediatric orthopedic patients.

The following texts will be helpful:

- *Core Knowledge in Pediatric Orthopedics*, 1st edition., Mosby, 2005

**B. Subspecialty Breakdown Throughout Residency (In Weeks) - *includes VA rotation***

<table>
<thead>
<tr>
<th>Subspecialty</th>
<th>PGY-2</th>
<th>PGY-3</th>
<th>PGY-4</th>
<th>PGY-5</th>
<th>Total</th>
<th>Percentage of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Reconstruction</td>
<td>6</td>
<td>18</td>
<td>6</td>
<td></td>
<td>30</td>
<td>16%</td>
</tr>
<tr>
<td>General*</td>
<td>12</td>
<td></td>
<td>6</td>
<td>12</td>
<td>30</td>
<td>16%</td>
</tr>
<tr>
<td>Trauma</td>
<td>6</td>
<td>18</td>
<td></td>
<td>6</td>
<td>30</td>
<td>16%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>12</td>
<td>12</td>
<td></td>
<td></td>
<td>24</td>
<td>13%</td>
</tr>
<tr>
<td>Sports</td>
<td>6</td>
<td>6</td>
<td>12</td>
<td></td>
<td>24</td>
<td>13%</td>
</tr>
<tr>
<td>Hands</td>
<td></td>
<td>12</td>
<td>6</td>
<td>18</td>
<td>30</td>
<td>9%</td>
</tr>
<tr>
<td>Spine</td>
<td>6</td>
<td>6</td>
<td></td>
<td>12</td>
<td>18</td>
<td>6%</td>
</tr>
<tr>
<td>Tumor</td>
<td>6</td>
<td></td>
<td>6</td>
<td></td>
<td>12</td>
<td>6%</td>
</tr>
<tr>
<td>Foot &amp; Ankle</td>
<td></td>
<td>6</td>
<td>6</td>
<td></td>
<td>12</td>
<td>6%</td>
</tr>
</tbody>
</table>
III. General Information

A. Parking
For parking permits and coupons please contact CHOP Security at ext. 4-4375. Satellite parking is also available and costs $45.00 for 10 coupons, which can be purchased at the cashier's desk and are payable by cash, check or credit card. For reimbursement, please contact the Security Department secretary. Courtesy parking at CHOP is available at these times (YOU MUST HAVE PROPER ID):

1. If you are on call, have your parking ticket stamped at the security desk on the first floor between the hours of 7:00 p.m. to 8:00 a.m.

Other Parking Options:
Penn Tower Hotel parking costs $8.00 per day.

B. Cafeteria
The main cafeteria is located on the first floor of the Main Hospital Building. The Abramson Center cafeteria is located on the first floor of the Abramson Center and is only open for breakfast and lunch. You will receive a meal card for each night you are on-call.

Food Court: Open 7 days a week
- Breakfast: 6:30-10:30 a.m.
- Lunch: 11 a.m.-3:30 p.m.
- Dinner: 4-7:30 p.m.

Doctor Coffee: 24 hours, cash only

Abramson Cafeteria: Open Monday to Friday
- Breakfast: 7:30-10:30 a.m.
- Lunch: 11 a.m.-2:30 p.m.
- Dinner: Closed
* Saturday to Sunday – CLOSED

Convenience / Gift Shops / Beverages and Packaged Meals
Shops @ CHOP Main
- Weekdays: 7 a.m.-midnight
- Weekends: 8 a.m.-8 p.m.

There are vending machines in the cafeteria, which is open 24 hours.
C. Library and copying

There are two copy machines in the orthopedic surgery office area on the second floor of the Wood Center.

The University of Pennsylvania Biomedical Library is located in the Johnson Pavilion behind CHOP. Regular hours are: Monday to Thursday, 8 a.m.-midnight; Friday 8 a.m.-10 p.m.; Saturday 9 a.m.-5 p.m.; and Sunday 10 a.m.-midnight. Summer and holiday hours will vary.

Copy machines are coin operated or accept cards, which may be purchased in the copying area of the library.

D. On-call room/email

The orthopedic residents’ room is 9022B and is located on the ninth floor.
The trauma residents’ room is 9403 and is located on the ninth floor.
Multipurpose resident area is 9 NW 57 and is located on the ninth floor.
Ortho closet 4C46, located between 4E and 4S
Do not leave valuables in the call rooms.
The orthopedic fellows office on the second floor of the Wood Center is Room 2417.

There is a generic e-mail account set up for the use of the residents. Residents are required to check this e-mail account frequently, as this is the way others within the department will communicate with you. The generic address is orthoresident@email.chop.edu. The password will be supplied to you.

E. I.D. badge, beeper and OR locker

When you start your rotation, see Security about obtaining an I.D. badge. You will be issued a beeper. You are financially responsible for the beeper during your rotation. Replacement batteries can be obtained from an orthopedic secretary. The main OR desk will assign you a locker. You will receive a locker assignment at orientation. Complete forms for scrubs.

F. Telephones and beeper paging

To access beepers from in-house, dial 81, then after the tone, dial the 5-digit beeper number, then the extension to be called, asterisk, your beeper number and the pound (#) key.
Nurses carry Ascom phones, 5 digit numbers are available from the unit clerk or staff directory.

To access beepers outside:
The paging access number is as follows: 267-426-8181
When these numbers are dialed, you will be prompted to enter a five-digit pin number. This is your beeper number (i.e., 10135). Once the pin number is entered, simply enter the call back number. There is no need to hit the pound (#) key, this will result in a busy signal.

**G. Smoke-free hospital**

Children’s Hospital is smoke-free. Smoking is not permitted anywhere in the building.

**IV. Orthopedic Guidelines**

**A. Morning Conferences**

1. Monday 6:45 a.m.: Pediatric Orthopedic Lecture
2. Tuesday 6:30 a.m.: Pediatric Orthopedic Lecture
3. Wednesday 6:30 a.m.: M & M/Indications (coordinated by fellows)
4. Thursday 6:45 a.m. or 7:30 a.m.: HUP Lecture/Grand Rounds
5. Friday 6:30 a.m.: Pediatric Orthopedic Lecture

A schedule of lecture topics is posted monthly and sent to Ortho Resident email.

**B. Weekly Clinic Schedule**

One resident must be in the office by 8 a.m.

<table>
<thead>
<tr>
<th>CHOP</th>
<th>OFFICE HOURS</th>
<th>OFFICE HOURS</th>
<th>OPERATING ROOM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>AM</td>
<td>PM</td>
<td>Flynn</td>
</tr>
<tr>
<td></td>
<td>Dormans – weeks 1,2,4</td>
<td>Dormans - weeks 1,2,4</td>
<td>Spiegel – weeks 1,2,4</td>
</tr>
<tr>
<td></td>
<td>Wells</td>
<td>Wells</td>
<td>Dormans – weeks 3,5</td>
</tr>
<tr>
<td></td>
<td>Sankar</td>
<td>Sankar</td>
<td>Lawrence</td>
</tr>
<tr>
<td></td>
<td>Campbell</td>
<td>Campbell</td>
<td>Horn – week 4</td>
</tr>
<tr>
<td></td>
<td>Carrigan – weeks 2,3,4,5</td>
<td>Carrigan – weeks 2,4,5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Davidson</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuesday</td>
<td>Drummond</td>
<td>Chang</td>
<td>Horn – weeks 1,4,5</td>
</tr>
<tr>
<td></td>
<td>Lawrence</td>
<td>Lawrence</td>
<td>Dormans</td>
</tr>
<tr>
<td></td>
<td>Flynn</td>
<td>Horn – weeks 2,3,4,5</td>
<td>Campbell</td>
</tr>
<tr>
<td></td>
<td>Spiegel</td>
<td>Spiegel</td>
<td>Wells – weeks 2,3,4,5</td>
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<tr>
<td></td>
<td>NP fracture clinic</td>
<td>Ganley – weeks 1,3,4,5</td>
<td></td>
</tr>
<tr>
<td>Wednesday</td>
<td>Sankar</td>
<td>Sankar</td>
<td>Dormans</td>
</tr>
<tr>
<td></td>
<td>Ecker</td>
<td>Drummond</td>
<td>Chang</td>
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<tr>
<td></td>
<td>Davidson</td>
<td>Davidson</td>
<td>Flynn – weeks 1,2,3,4</td>
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<td></td>
<td>Ganley</td>
<td>Ganley</td>
<td>Carrigan</td>
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<td></td>
<td>Spiegel</td>
<td>Spiegel</td>
<td>Campbell – weeks 1,3,5</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Ganley – week 5</td>
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<tr>
<td>Thursday</td>
<td>Dormans</td>
<td>Dormans</td>
<td>Davidson</td>
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<tr>
<td>----------</td>
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<td>---------</td>
<td>----------</td>
</tr>
<tr>
<td>Ecker</td>
<td>Lee</td>
<td>Spiegel – weeks 1,3,5</td>
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<tr>
<td>Horn</td>
<td>Horn</td>
<td>Ganley</td>
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<tr>
<td>Drummond</td>
<td>Drummond</td>
<td>Flynn – week 2</td>
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<tr>
<td>Chang – weeks 1 &amp; 3</td>
<td></td>
<td>Baldwin – weeks 2,4</td>
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<tr>
<td></td>
<td></td>
<td>Sankar – week 4</td>
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<thead>
<tr>
<th>Friday</th>
<th>Chang – weeks 1,2,3,5</th>
<th>Spiegel – weeks 1,2,3,5</th>
<th>Horn</th>
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<tbody>
<tr>
<td>Wells – weeks 2,3,4</td>
<td>Wells – weeks 2,3,4</td>
<td>Wells – weeks 1,5</td>
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<td>Flynn</td>
<td>Flynn</td>
<td>Sankar – weeks 1,2,3,4</td>
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<td>Campbell</td>
<td>Campbell</td>
<td>Carrigan</td>
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<tr>
<td>Master</td>
<td>Carrigan – weeks 1,2,3,4</td>
<td>Davidson</td>
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<tr>
<td>Davidson – week 1</td>
<td>Baldwin – weeks 1,3,4</td>
<td>Chang – weeks 1,2,3,5</td>
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</tr>
</tbody>
</table>

Satellite phone numbers

- Bucks County, PA: 215-997-5730
- Exton, PA: 610-594-9008
- King of Prussia, PA: 610-768-9470
- Voorhees, NJ: 856-435-1300
- Virtua, NJ: 267-425-5400
- Princeton, NJ: 609-520-1717
- Atlantic County, NJ: 609-677-7895

C. Personnel

1. Office staff
   - Nancy Collins, Division Manager
   - Linda Pellegrino, Operations Manager
   - Colleen Berry, Academic Secretary (JPD)
   - Catherine O’Shea, Division Secretary (JPD)
   - Carol Kenny, Secretary (TJG, DSD)
   - Joanne Hofmann, Secretary (KB, MLE)
   - Joanne Miller, Secretary (JMF, BSL)
   - Donna Dougherty, Secretary (RSD)
   - Ellen Dever, Secretary (BDH, BC, DS)
   - Darlene Spino, Secretary (LW)
   - Denise Caruso, Secretary (RMC)
   - Daniel Piersa, Secretary (JTL, WS)
   - Katie Mroczka, Secretary/Appointment Coordinator
   - Gina Hunt, Surgery Coordinator
   - Raquel Taylor, Surgery Coordinator
   - Tammy Solivan, Surgery Coordinator
   - Maria Tanczak, Surgery Coordinator
   - Marie Lombardi, Billing Coordinator
Beth Andrews, Billing Coordinator
Atiya Toliver, Appointment Coordinator
Sunny Pembleton, Appointment/Surgery Coordinator
Maria Colon, Appointment Coordinator
Joe Watt, Appointment Coordinator
Melanie Davis, Appointment Coordinator
Helen Giordano, Appointment Coordinator
Irene Stewart, Appointment Coordinator
Netra Thomas, Appointment Coordinator
Kisha Stephens, Appointment Coordinator
Lisa Kozarski, Appointment Coordinator
Kim Lavelle, Appointment Coordinator
Trisha Renzi, Appointment Coordinator
Glynis Meyers, Appointment Scheduler
Tracy Hayden, Appointment Scheduler
Lakicha Williams, Appointment Scheduler
Nicole Gigliotti, Appointment Scheduler
Francene Murray, Appointment Scheduler
Melissa Gunderson, Research Coordinator
Jennifer Talarico, Research Coordinator
Jessica De Sabato, Research Coordinator

2. Front desk staff
   Cathy Chase

3. Orthopedic technicians
   Assist with spica casting, traction set-up and cast removal
   Joe Monteleone
   Elizabeth Robinson
   Mary Cuthbert
   Leroy White

D. Mid-level providers
1. Clinical coordinator - Meg Morro, BS, RN
   Manages weekly clinic assignments and coordinates care of patients in clinic
   (patient educations, telephone follow-up, and cast room)

2. Nurses and nurse practitioners:
   Outpatient assessment and management
   Kathy Abel, MSN, CRNP, RN, ONC
   Colleen Colbridge-Green, MSN, CPNP-PC
   Sharon Farrell, MSN, CRNP
   Bernadette Egan Gerardi, MSN, CRNP
   Diane M. Hartman, BSN, RN, CCRC
   Joy C. Kerr, BSN, CNOR, CNFA
   Brian McCaffrey, BSN, BS, RN
   Kristen Pryor McLaughlin, MSN, CPNP, RN
Inpatient assessment and management
   Kelly Ryan, MSN, CRNP

3. Physician Assistants
   Outpatient assessment and management
   Amanda Bearer, PA-C
   Paul D. Bradford, PA-C
   Meaghan E. Jones, MS, PA-C, ATC
   Jason Katz, PA-C, MHS
   Houn P. Lin, MPAS, PA-C
   Adam J. Moore, PA-C

4. Athletic Trainers
   Dzovig Essajanian, BS, ATC
   Lauren Farabaugh, ATC

E. Teaching
   1. A lecture schedule which covers a core curriculum of pediatric orthopedics will be provided.
   2. Journal Club materials are distributed the third month of the rotation (you should read topics in advance). The fellows and residents should have cases ready for M&M (fellow) and fracture (residents) conferences.
   3. Tumor pathology teaching file.
   4. Books, journals and CD-ROMs are available in the department (do not remove them from the Orthopedic library).

F. Operating room
   1. OR Start Time
      a. Attending calls in for start of day huddle at 7:15 a.m. when the attending physician discusses cases for the day with nursing and anesthesia
      b. Goal is start time at 7:30 a.m.
      c. Only attending and fellows site mark, residents do not site mark
   2. A pediatric orthopedic rotation may involve less operative experience due to the nature of the patient population. Operative site is to be stamped with “tumbler” after identifying the patient by an attending or fellow.
   3. The weekly OR schedule is posted on the bulletin board of the residents’ office.
   4. Booking OR cases in the middle of the night:
15

- Fill out the add on sheets and drop off at desk
- Speak to OR charge nurse about add on
- Then page anesthesia 10345

5. The resident/fellow who is scrubbing for a case is expected to:
   a. Review the chart and X-rays, preferably with the attending the night before surgery
   b. Bring all X-rays for all the day’s cases to the OR on the morning of the surgery prior to the first case so the team can review the cases and discuss the plan of care
   c. Place all intraoperative x-ray orders prior to start of case as well as TED stocking orders for sports procedures
   d. For arthrograms, bone cysts, and any other cases that use contrast document contrast in the form of an order from the pharmacy in EPIC, the resident or fellow can sign the request as a verbal order sent to the ordering physician for approval
   e. At the end of the case
      - Write the complete discharge note in EPIC (WB status, Meds.) and call 215-590-1527 for a follow-up appointment.
      - Place a prescription with a DEA # for post-op analgesic for home in the patient’s chart (print from EPIC)

6. Charts and X-rays are by the surgery coordinators’ desks in the office area.
7. Patient X-rays should be taken to the OR for the case.
   ** All pre-op scoliosis films are to be returned to the surgery scheduler or the radiology file room to be available for the 1 week post-op appointment.
8. Give resident assignments for weekly cases to Marie Melhuish in the OR on Monday morning for posting on the operating room schedule.
9. Residents should be in the OR at 7:15 a.m. (except Thursday – OR start time is 8:15 a.m.) This is the scheduled surgical start time. OR nurses and/or resident should page attending for later cases when the patient arrives in the room -- prior to the induction of anesthesia -- so attending will have sufficient notice to proceed to surgery.
10. The OR orthopedic specialty team consists of Michele Friday, Jeanne Goodwin and Teresa Weckesser. They coordinate intra-operative equipment and supplies. Check to be sure that special equipment is available.
11. OR Requests
   a. During business hours: Fill out a pre-admission form and take the chart, patient and form to the surgery coordinators (Gina Hunt, Maria Tanczak, Raquel Taylor or Tammy Solivan).
   b. After hours/weekends: Go to the OR and fill out a request form. Contact Nursing (ext. 4-3261) and Anesthesia On-Call. Be sure to call Anesthesia as you are scheduling the case so there will be no delay.

12. OR dictations are done by the attending
13. Please keep an OR log of operative cases and fracture reductions. Submit the log (with summary totals) to Dr. Dormans during your exit interview at the end of the rotation.
14. One parent is permitted in the recovery room and cannot trade places with the other parent.

15. Day Surgery
   a. PT order for crutch training needed with weight bearing status.
   b. Inform families that an overnight stay has been changed to a day surgery status.
   c. Prescriptions must have a DEA number that can be filled outside of the Hospital, prescriptions with the CHOP DEA number cannot be filled by outside pharmacies. If you write a script with a CHOP DEA number, advise the family pre-op to have it filled at the CHOP pharmacy. Day surgery RNs can “tube” it down for parents.
   d. Ask the parent or child if they prefer liquid or tablets for pain medication. Liquid oxycodone should be filled at CHOP. Few outside pharmacies have it. Write the same dose on prescription as in EPIC.
   e. Write for an appropriate dose in EPIC. Dosing info can be found on the daily inpatient list. (See section 18 OPD Pharmacy Prescription guidelines).

G. Pre-admission testing

1. Consents and H & P are to be completed by residents in the office when surgery is scheduled. The on-call resident will be paged for pre-visits to obtain consent and H&P if this is not done.
2. PAT is usually scheduled within two weeks of surgery. If H & P is older than 30 days, an update will need to be completed. You may be called by the day surgery pre-op area to complete the update.
3. Consents must be signed by the attending and legal guardian. Legal guardians (other than parents) must have court papers to validate their status. Remember to check the box for blood transfusion during this admission.
4. Children with heart murmurs need to be evaluated by Cardiology unless the family has a letter from a cardiologist.

H. Orthopedic Fellow Guidelines

The clinical fellows are responsible for gaining experience in the operating room and the clinics to obtain a broad exposure to pediatric orthopedics.

Remember to collect your surgical cases for review with Dr. Dormans at your quarterly meeting. Please contact Catherine O’Shea to schedule these meetings with Dr. Dormans.

ACGME GUIDELINES for Residents and Fellows:
All Orthopedic Surgery residents in their PGY-2 through PGY-5 years must report operative procedures and manipulations for which they were resident surgeons or assistants. Procedures which residents observe should not be reported.

All operative procedures and manipulations, in the operating room, emergency room, or any other venue, must be reported.
In rare circumstances, cases will involve more than five CPT Codes. Residents who perform such a procedure should select and **report only five** CPT Codes.

CPT Codes must be entered in accordance with the guidelines in the most recent *Complete Global Service Data for Orthopedic Surgery* (published by the American Academy of Orthopedic Surgeons) and most recent *Current Procedural Terminology* (published by the American Medical Association).

For a fellow, 1,000 for one year; 200 for residents for 3 months

Fellows and residents should discuss the coding with the attending surgeon at the end of each case to insure correct coding per ACGME guidelines.

1. OR: The fellow who scrubs in for a case is expected to:
   a. Review the chart and X-rays, preferably with the attending, the night before surgery.
   b. Bring all **unscanned** X-rays for all the day’s cases to the OR on the morning of the surgery prior to the first case so the team can review the cases and discuss the plan of care.
   c. Write the plan of care (on the same pages as the box with the operative procedure) that includes weight-bearing status, wear time for immobilization device, drain, dressing, etc.
   d. Complete physician discharge note and summary of hospital course in EPIC to include WB status, return appointment to call 215-590-1527
   e. Place a prescription with the DEA # for post-op analgesic for home in the patient’s chart printed from EPIC.
   f. Call the on-call resident beeper 11014 to give report and add to daily list.

2. Dormans’ service responsibilities:
   a. Preop
      • The major focus is the patient. Everything we do is for the patient. We have an incredible responsibility to these children and their families. Anything and everything we do could have a drastic influence on the entire rest of their lives. We cannot underestimate this.
      • If the fellow is unable to scrub for a surgery, Dr. Dormans needs to know this at least 1 day in advance. Residents with less experience will need more supervision from Dr. Dormans than an experienced fellow. For planning purposes, Dr. Dormans needs to know this for every surgery. This communication is essential.
      • It’s imperative the resident and Dr. Dormans have some communication at least one day before surgery or even several days before surgery, especially for larger cases. Many of the sarcoma resections and reconstructions and complex spines require intense planning and attention to detail. The resident is responsible for
working with the surgical scheduler (Tammy Solivan x47892) and Jason Katz, PA-C, to verify and check that everything is in order.

- There should be direct communication between resident and Dr. Dormans at least the day before surgery. If Dr. Dormans is out of town, this can be done via email or via cell phone. Contact Dr. Dormans secretary for his cell number.

- For the endoprosthetic reconstructions, there are several things that can go wrong. The “what can go wrong approach” is especially helpful for these cases. Making sure that the endoprosthetic device is available and all arrangements have been made earlier with either Stryker Howmedica or BioMet is key. Residents are encouraged to directly contact the endoprosthetic representative to verify the situation.

- Making sure that the consents are signed, the NPO status is understood, and the time to arrive at the hospital is understood are all especially important. Many of these patients have outside X-rays and advanced imaging studies. If they’re not in the CHOP system, please call the family and verify that they have them and are bringing them. At the same time, please verify NPO status, arrival time, showering, nutritional preparation, etc. This can be coordinated with the scheduling secretary.

- For **complex spinal deformity cases**, there is a similar experience. Conferring with the Medtronic representative is especially important. Verifying spinal cord monitoring, packed red cells, etc. is especially important. For scoliosis cases, please review everything with Medtronic in advance. Dr. Dormans would like residents to be actively involved in the process of selecting fusion levels and instrumentation construct, rod sizes, etc.

- It is the resident’s responsibility to pull and review the X-rays and other advanced imaging before the surgery and go through this active learning process. Please also review the office chart.

- Please do not take the office chart to the OR … It is OK to make a photocopy of pertinent information and take that to the OR.

- It is especially important to prepare and read for the case in advance. The attending surgeon can usually -- if not always -- tell if the assistant surgeon has read and prepared. This attention to detail is one of the central components of being a successful surgeon.

- Place all intraoperative X-ray orders prior to start of case.

- For arthrograms, bone cysts, and any other cases that use contrast document contrast in the form of an order from the pharmacy in EPIC. The resident or fellow can then sign the request as a verbal order sent to the ordering physician for approval

b. Intra op

- On the morning of surgery it is responsibility of the resident or fellow scrubbing the case to review all the cases for that day with the
anesthesia and nursing teams. During this review, discussion should occur about the need (or not) for regional blocks.

- As always, please call Dr. Dormans on his cell phone when the anesthetic team is intubating the patient. This will give Dr. Dormans time to get up to the operating room with sufficient time rather than getting the call after the patient is prepped and draped. The anesthetic “clock” begins ticking when the patient is ready.
- For osteoid osteomas, make sure table is compatible with O-arm use.
- For osteoblastoma, ABC, chondroblastoma, order phenol on EPIC preop and ask nurses to obtain and have high-speed Burr available.
- For all cases, it’s especially important to have the images up and ready to go in the OR. Usually these will be PACS images. They should be up on the computer with the best images selected.
- For large sarcoma cases, it’s often helpful to print out hard copies of the pre-chemo MRI studies to have them up on the standard view boxes. Both pre and post-chemo images are especially helpful in navigating through the case. The printing of some of these images should be done a day or two in advance.
- For scoliosis cases, it’s important to have the 3 foot PA/Lat films and the bending films up on the view boxes in addition to any advanced imaging. It’s important to review advanced imaging such as any MRIs that may have been done soon before surgery to be sure that there’s no undetected intra-spinal CNS problems. Attention to detail is the key component to successful surgery.
- It’s especially important for MHE patients to verify which lesions are being removed before the patient goes to sleep. They have hundreds of lesions and if we don’t identify the right ones we could be in a difficult situation after the patient is asleep.
- Please do an alcohol pre-op with gloves prior to prepping and draping. We use a sterile u-drape applied with gloves in a semi-sterile technique always. To understand the importance of this, look at old fashioned X-rays sometime. There are fingerprints all over the X-rays. This would be the case if you apply the u-drape or didn’t; use the u-drape and prepare for the prep without washing your hands or using gloves. This attention to detail is exceedingly important.
- The operative note should be partially filled out prior the beginning of the case.

c. Post-op

- Post-operatively, it is your responsibility as the “educational co-surgeon” to personally monitor the patient. It is especially important that you -- as the person who was there for the surgery -- monitor the patient and direct their post-operative care.
- Please work closely with Ortho in-patient NPs to make sure that the discharge instructions are complete and documented. Families will
pick up on inconsistencies and see this as substandard care. Your leadership in this area is appreciated.

d. General
- Please help us create better systems. Running an academic clinical practice is a bit like being a gardener. One has to be out in the garden pulling weeds every single day for things to go well. Your input, comments and suggestions are important and needed.

3. Children’s Seashore House
Fellows are responsible for the orthopedic management of the patients on the rehabilitation floor (3rd) of Seashore House.

A written note within 24 hours of admission (new CSH names will appear on daily inpatient list) documenting plan to include DVT prophylaxis, weight-bearing status, dressing changes, immobilization device wear time, and plan to see attending orthopedic MD.

Weekly rounds on Thursdays at 7:30 a.m. in the NP office on 3W to update plans facilitates care of our patients.

Your NP contacts:
- Sabrina Zanowick Beeper 16890
- Cindy Alebrando Beeper 19503
- Hope de la Cruz Beeper 11268
- Susan Fendrick 16974
- Jackie Crawford NP 16950

4. Conferences (fellow presentation)
   I. Wednesday case conference (M & M and indications)
- Attendees – all orthopedic residents currently rotating at CHOP, med students rotating on the service, most attendings
- Topics for cases – M & M, interesting surgical cases, focusing in indications and surgical decision making, rarely a question case requested by an attending
- Power point format with basic history and pertinent imaging studies.
- Cases for discussion should be sent to the moderating attending by the Monday of the week, to be reviewed.
- If an M & M is to be presented, the attending should be contacted in advance to ensure that he/she will be in attendance

   III. Tumor Board
- Weekly Thursday conference which we are almost always unable to attend due to busy Thursday OR schedules
- Ortho assigned to present 2 or 3 times each year
- Case based presentation on a patient treated by orthopedics here and the oncologists
- Power point presentation about 1 hour long
• Arrange for a pathologist and radiologist to be present to discuss their portions
• The pathologists are happy to review the case in advance and attend the conference
• The radiologists have not typically attended the conference

IV. Medical students
• There are two levels of medical students who may rotate through CHOP. Ortho 200 is a one week course required of all Penn medical students. Ortho 304 is the one month long “sub-internship” offered to both senior Penn medical students and rotators from other medical schools

  • **Ortho 200**: As part of this course, 1-2 students may rotate through CHOP for one or more days of their one week experience. The commitment lasts from 8 am until 12 pm as they must return to HUP for didactic activities. Ortho contact person is Joseph Bernstein and Jaimo Ahn at HUP. Students who will be visiting CHOP are assigned prior to the start of the week to specific attending by Dr. Sankar in coordination with Dr. Bernstein and Ahn. No evaluations are required at the end of the rotation.

  • **Ortho 304**: 1-2 students spend one month on service. The majority of these students are interested in pursuing a career in orthopedics. They will be integrated within the resident team, and will also shadow one or two attending surgeons for 1-2 weeks during their rotation. These students are graded, and their evaluation is based on 1) the resident team, 2) the fellows, and 3) one or more attending surgeons who worked with them on the rotation. Students will meet with Dr. Spiegel at the beginning and the end of their rotation.

• Occasionally, students will be present and normal morning resident conference

V. Visiting professor
• Once a year there is a pediatric visiting professor, typically on a Thursday
• The visiting professor attends teaching cases with the residents at HUP at 6:30-7:30 a.m.
• Fellow is responsible for assembling cases in the visiting professor’s area of interest and expertise
• Often followed by the visiting professor giving grand rounds
• Then return to CHOP for more case presentations assembled by the fellow

VI. Reimbursement policy for clinical and research FELLOW travel

  a. Clinical and research fellows are eligible for reimbursement for up to two meetings per year plus any meeting at which you present a paper or have a podium presentation. A POSNA meeting should be one of the above meetings.

  b. There is a cap on reimbursements:
- Up to $3,000 total for two non-presenting meetings (e.g. Up to $1500 per meeting for the two or similar combination). No more than six weekdays away (i.e. two Wed-Fri meetings.)
- An additional $1500 per meeting for those who are pre-approved for podium presentations (not posters) with no more than six weekdays away (i.e. two Wed-Fri meetings).
- Fellows will be assigned, a secretary to help with reimbursements.
- Travel (hotels, airfare and course registration) can be set-up in advance via ITT travel.
- Costs for additional meetings are the responsibility of the fellow; however, additional requests are considered on a case-by-case basis, especially if presenting a paper—see resident reimbursement section below.
- For any/all we require preapproval and early booking (greater than 2-3 months in advance) for flights (coach).
- Applications can be made on a case by case basis. See Nancy Collins for an application form.

   c. If industry is paying for you, this needs to be discussed in advance with Dr. Dormans and would preclude additional reimbursement (i.e. can only be reimbursed once for paid expenses).

I. Research

   Topics will be discussed in a morning conference, usually once a month

   1. Research Projects
      - X-rays for research projects must be kept in the Wood Center radiology reading room
      - Charts for research projects must be requested from records custodian
      - Research coordinators are responsible for attending-related research work; exceptions are made only at the discretion of the attendings.

   Residents and fellows are expected to do their own literature searches and collect their own patient data. You may not delegate these to research coordinators. Do not use research coordinators or CHOP resources for outside projects

   2. Policy for Resident Reimbursement
      For meeting presentations (and any other reimbursement and requests relating to presentations at a meeting)
      - The Division of Orthopedic Surgery at CHOP will consider formal written requests for resident reimbursement for presentation of podium papers at meetings. Residents who are actually presenting a CHOP Orthopedic paper at regional or national meetings are eligible for reimbursement or appropriate travel expenses from CHOP Orthopedics. Co-authors who do not present the paper are NOT considered for reimbursement. Exceptions are made on a case-by-case basis. All requests for reimbursements must be submitted in writing to Dr. Dormans in advance of abstract submission for paper presentations to be considered.
• **MEDICAL STUDENTS** must discuss with Dr. Dormans prior to submission of paper. Approval given on a case-by-case basis (similar points above apply to fellows as well)
• Reimbursement will only be given for podium papers (not posters)
• If there is material being presented from other institutions (where you have previously done training or research) and if you have a paper with CHOP, Orthopedics will “split” costs with the other institution/Penn
• Reimbursement is only given after the meeting with original receipts; however, pre-reimbursement may be approved provided the request comes 6-8 weeks prior to the meeting
• Please see Dr. Dormans’ secretary, Catherine O’Shea, to complete the appropriate paperwork for reimbursement
• Inform Dr. Dormans prior to a meeting/course if industry is paying for you. You cannot be reimbursed for any expenses that are already being covered by another institution or by industry.

3. CHOP Model of Research
   • Clinical experience directs focus
   • Identify a need/unsolved problem preferable
   • Generate a hypothesis
   • Careful literature search up front
   • Proposal of what data needs to be collected and cost
   • IRB
   • Attending-drive careful review of all spreadsheets several times early on with careful scrutiny and dedication to honest collection of all data points
   • Review of data and points by all co-authors early (all co-authors need to be “in the loop” early)
   • Review of drafts
   • Make sure conclusions are justified by results
   • Have all co-authors sign off on abstract before a paper is submitted for a meeting, etc.

4. OREF-OO Traveling Fellowship
   Final year orthopedic residents are invited to apply for the OREF-OO Traveling Fellowship. Funded by a grant from the Orthopedic Research and Education Foundation, this fellowship supports senior year resident rotations to active Orthopedics Overseas sites. For the resident, this experience provides exposure to a wide range of pathologies not commonly seen in the United States, as well as an introduction to the issues in effective cross-cultural communication.

Senior residents interested in applying for the OREF-OO Traveling Fellowship should send a CV with cover letter outlining the reasons for their interest and a letter of recommendation from the director of their residency program. These application materials should be sent to Nancy A. Kelly, M.H.S., Executive Director, Orthopedics Overseas, 1900 L St. NW, Suite 310, Washington DC, 20036. Admissions are on a rolling basis. Electronic submissions are encouraged.
Please send all materials to info@hvousa.org and indicate in the subject line
“OREF GRANT APPLICANT.” For more information, please visit the HVO Web site (www.hvousa.org).

J. On-Call Schedule

1. The schedule must be arranged by the 25th of the preceding month. Please include
away time on the schedule. Please send a copy to Dr. Baldwin and discuss any
conflicts or problems in advance. Notify Donna Dougherty of any change to call schedule so that she can update the operator.

2. In accordance with current ACGME rules, call must be no more frequent than q3
averaged over any given one month period.

3. Residents sleep in-house. You will be given a door code and room number.

4. The on-call beeper number is 11014. All calls go to this beeper. The on-call
resident is responsible for solving the problem or for finding another resident to
respond.

The policy and procedure for paging orthopedics:
   If a call comes in asking for orthopedics resident, the resident is paged
   If no answer in 3 to 5 minutes, they are called on their cell phones
   If no answer in 3-5 minutes, the fellow is called on cell phone (if weekday)…
   If no answer in 3 to 5 minutes (or weekend) the attending is called on their
   cell phone….
   If still no answer the Ortho Division Chief is called on cell phone
   Please be sure you have cell phone number for Joann D’Italia, Bev Teti, Jason
   Katz, and Meg Morro. Please see Ortho phone list.

5. Update the daily list on the computer.

6. Vacation/Interview Schedule (Must complete a time-off request).
   Fellows must complete the form and submit it to Catherine O’Shea.

7. Generally, only one resident can be off at a time. Individual issues must be
discussed with the chief(s) and Dr. Dormans.

8. Vacation time during this rotation as per your program, maximum 5 consecutive
days per 6-week block.

   • Clinical fellows are allotted 20 vacation days per 12 month fellowship.
     (per CHOP policy)
   • Non-clinical fellows accrue 7.69 hours biweekly (maximum 25 days per
    12 month fellowship). (per CHOP policy)
Residents are allowed one week vacation during their rotation (included in the three weeks’ vacation approved by HUP)

9. CHOP Orthopedic Surgery ACGME Resident Duty Hours Policy
The ACGME duty hour regulation went into effect 7/1/03. Requirements are as follows:

a. Duty hours are defined as all clinical and academic activities related to the resident program (both inpatient and outpatient). Duty hours do not include reading and preparation time spent away from the duty site.

b. Duty hours must be limited to 80 hours per week, averaged over a 4-week period, inclusive of all in-house activities.

c. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call.

d. A 10-hour time period for rest and personal activities must be provided between all daily duty periods, after in-house call.

e. In-house call must occur no more frequently than every 3 nights, averaged over a 4-week period.

f. Continuous outside duty must not exceed 24 consecutive hours. Residents may remain on duty for up to 4 additional hours to participate in didactic activities, maintain continuity of medical and surgical care, transfer care of patients or conduct outpatient continuity clinics. Therefore, maximum continuous in-Hospital time must never exceed 28 hours (as of 7/1/12).

g. No new patient may be accepted after 24 hours of continuous duty.

Beginning 7/1/03:

- Each resident should monitor his/her call and weekly hours to meet the ACGME requirements listed above.

- The resident on-call must leave by 10 a.m. the next day (as of July 2012).

- The next morning, the on-call resident should round and sign out patients admitted on-call (e.g., CRPP supracondylar fracture), but must be out of the hospital 10 a.m.

- The remaining residents (depending on vacation, away time, presence of Monmouth resident and other factors there will be between 2 to 4 residents available, one of whom will have the 11014 call beeper) will cover all other Orthopedic clinical responsibilities:

1. Any ED or inpatient emergency (codes, trauma, etc.)
2. Any non-covered OR case
3. Routine ED consults
4. Floor work and discharge planning
5. Orthopedic office hours

Although these priorities are generally appropriate, there will be times when the priorities will be different than what is listed. The bottom line is good communication and prioritization of the patient care and family needs. Communication between the resident and the attending staff is essential, especially from the attending on-call. If necessary, refer to our
back-up call policy. The attending should be asked to get involved in the Emergency Room or for floor calls if the occasional situation arises that there is a difficult conflict.

h. Cases are selected the Friday prior during Resident Orthopedic lecture. The resident carrying the 11014 call beeper should not be assigned solo coverage of a major case, if possible. The chiefs will also assign coverage of add-on cases, sedation unit cases and Orthopedic office hours at morning conference, in consultation with the clinical fellow(s).

i. The clinical fellow(s) must be available to scrub in on any uncovered cases. Second priority is uncovered Orthopedic office hours. The clinical fellow(s) should meet with the chief residents to review the elective surgery resident coverage each week and the add-on cases, sedation unit cases and Orthopedic office hours coverage each morning.

K. Emergency Department

1. Fracture Referrals (Acute traumatic injuries)
   A. Orthopedic sedation/cohort
      1. Patients to be put in Cohort
         a. From triage, extremity injuries with obvious deformities and patients with nail bed injuries.
         b. From other teams, found to have an orthopedic injury requiring sedation and reduction if there is an open bed in the cohort. The mini-C arm can be used in all rooms so patients requiring sedation and reduction should not wait when the cohort rooms are full. When all the cohort rooms are full, care should be provided in their current location.
         c. Other patients needing reduction or orthopedic care may be sent to the cohort when there are available beds.
         d. At the same time, the Team 2 attending should help direct the order in which patients are cared for by the orthopedist in all teams in the ED
      2. Dates/Times of Operation
         a. May 2012 – Sat/Sun 3 p.m.-3 a.m. in Rooms 27 – 32
         b. June 2012 – August 2012: Ortho Cohort 7 days per week 3 p.m.-3 a.m. in Rooms 27 – 32
         c. Sept. 2012 – Ortho Sat/Sun 3 p.m.-3 a.m. in Rooms 27 – 32
         d. Cohort will function 3 p.m.-3 a.m.
         e. At 2 p.m., patients who fit cohort definition should be placed there preferentially.
      3. Location/Rooms
         Rooms 27 – 32; the aim is to use the cohort for the majority of patients requiring orthopedic care in the ED. However, remember
orthopedic care and use of the C arm can occur in any room in the ED.

4. Patient Flow/Provision of Care
   a. Cohort will be staffed by 3 RN’s and 1 Tech (Ortho Tech).
   b. *Patients from other teams needing sedation and reduction* will receive initial care (including provision of analgesia and radiography) in the team they are initially placed in.
   c. Once moved, *the patient should be transferred to the cohort and care transferred to the nurses in the cohort and Team 2 physicians.*
   d. Physician/NP care in the cohort will be provided by all Team 2 physicians and nurse practitioners. There will not be a dedicated orthopedics cohort physician/NP. Team 2 physicians/NPs will pick these patients up *in turn.* Team 2 Attending will monitor patient flow.

5. Overnight function when Team 2 is covered by Fellow (May and June 2012 only):
   a. Leave 3 rooms open to be used as “cohort” rooms.
   b. Evening team will make every effort to complete sedations before midnight sign over.
   c. Patients in Team 1 should be sedated and treated there. If a patient in Team 2 requires sedation/reduction, the Fellow will direct that care under the supervision of the overnight attending physician. The overnight (Team 1) attending and charge nurse will monitor patient flow and individual patient and ED needs and assign patients to rooms accordingly.
   d. Nights when there is a PEM attending in Team 2 overnight, continue to cohort patients in Team 2 until there are no more patients and Team 2 will care for patients.

6. Ortho Tech Role:
   a. The orthopedic tech will report to the ED Charge Nurse. In times of high acuity and work load in the ED, the ED Flow Facilitator/Charge Nurse may need to assign the tech to non-orthopedic duties.
   b. The in – house, Orthopedics On – Call Physician will help the technician triage and determine the priority of the orthopedic work the technician is assisting with in the ED.
   c. The technician will assist the on-call orthopedist in the completion of tasks in the ED, and place splints and casts as requested by the ED team or the orthopedist on – call. The orthopedist on – call physician will supervise the orthopedic tech as needed and will provide consultation to the tech upon the tech’s request.
d. During the (orthopedically) quieter winter months and any time during their shifts when the technician is not busy with orthopedic duties, the technician will be deployed in other roles in the Emergency Department.

e. The ED Charge Nurse has the authority to deploy the tech(s) to other duties in the ED at any time based on ED patient volume and acuity.

7. Patient Tracking – Ortho Consults in EPIC
a. Orthopedic Consults called from any team should be noted in EPIC.
b. Before calling a consult, the team caring for that patient can refer to the ED Track Board to attempt to determine if the orthopedist is in the ED and may have direct communication instead of paging.
c. Once called, the orthopedic consult should be noted in the Consult field of EPIC

d. Since most orthopedic patients will be in Team 2, it is hoped that the Team 2 Attending will act as a liaison with the orthopedist on – call. The Team 2 attending may be able to help determine order of care for patients in all teams in the ED, etc.

8. Radiology Ordering/Availability
a. Most x-rays for extremity trauma should be ordered from triage. Patients with obvious deformities will still go directly to treatment rooms in the back.
b. If radiology technologists have concerns about the x-rays ordered they must talk to the ordering attending.
c. When x-ray is ordered in Triage:
   i. Triage nurse will choose “Waiting in Radiology” from EPIC “Transport for Radiology” drop down.
   ii. Triage Tech or Nurse will walk patient to the radiology waiting area by Team 4.
   iii. When x-ray is complete, Radiology Technologist will bring patient to Waiting Area.
   iv. Triage, Flow Facilitator, Team 2 Team Leader and Team 2 Attending will review x-rays done in triage. Patients needing reduction should be placed in the cohort.

d. ED physicians, nurses and the orthopedists will keep the ED radiology technologists informed of planned patient flow in the cohort by using the “Transport for Radiology” drop down. The new choice, “Fluoro C-arm” is chosen so the radiology technologists can plan their work flows. When ready, the team should call the technologists to alert them the team is ready.
B. Casting in the ED

The decision to cast or splint should be a joint one (shared between the orthopedic and the ED physicians).

At times, the "orthopedic tech" can run the films to the resident (or the resident can look at CHOP films from a distance electronically) and a decision can be made. If, in the judgment of the orthopedics resident a splint is okay with appropriate follow-up then that should be alright. If the orthopedics resident feels a cast can be placed safely, then the orthopedic tech can place a cast. In order to place casts, orthopedic techs must have been given clearance to cast by the orthopedic team (attendings and Joe Monteleone, et al).

If at any time an ED attending feels that management dictated from afar is not appropriate, those concerns should be voiced to the orthopedic resident and a plan developed. If the orthopedic resident is not available, that means that their attending is probably in the hospital with them and they could be involved in the discussion as well. If it is felt that the risks of a cast outweigh the benefits then a splint should be placed.

The orthopedic techs are all capable of placing simple casts. Simple buckle fractures can often go home in a prefab black splint with Velcro (supported by literature).

If the ED attending wants to have a cast placed, the techs can do that. IF the ED attending wants a splint - the techs can do that. If the ED attending wants orthopedic input, has any questions or does not feel the patient needs to wait for the orthopedist to actually place splint/cast then the orthopedist can be contacted, films can be reviewed as well as the history and a decision between the two can be made.

After a cast is placed, if either the orthopedic tech or the ED attending have any concerns about the patient or the cast, the on-call orthopedist should be called and must respond to the ED to examine the patient and inspect the cast.

At any time, if the Ortho Tech is uncomfortable with what they are being asked to do, they should discuss this immediately with the ED attending caring for the patient. If there is any concern or question after this conversation, the care of the patient should be discussed with the on-call orthopedist. This discussion should involve review of the patient’s films and if necessary, examination of the patient by the orthopedist.

Unless an Orthopedic Attending is present in the ED, the ED attending is ultimately the attending of record and needs to make and take responsibility for the final decision unless orthopedic comes and takes over the orthopedic care of the patient.

- Division of Orthopedic Surgery Policy and Procedure
C. Fracture Care Scheduling
Operators, schedulers, coordinators, and secretaries should abide by a high priority "open door policy" to book any new fracture with any doctor in Orthopedics ASAP (within 24 hours). (ACCESSIBLE)

1. Acute Traumatic Injuries
   A. Fractures from CHOP Emergency Room.
      There are 2 groups of patients with fractures seen at CHOP:
      - Those seen by Orthopedics in the ED or hospital (i.e. yellow consult sheets)
      - Those seen by the ED (ED physician or ED resident) (i.e. ED generated sheet)
      Families should be contacted by our staff, based on the information on the yellow sheets or the ED-generated sheets. (PRO-ACTIVE)

B. For those seen by Ortho in the ED or Hospital (i.e. yellow consult sheet):
The yellow consult sheets will be collected by the doctor on call for disposition, then forwarded to his coordinator to call those patients to offer an appointment with that doctor based on his instructions. If patients cannot be seen within an appropriate length of time, or if they are not happy with the time frame; i.e., too long a wait, efforts should be made to accommodate them with another time or another doctor.

C. For those seen in the ED by ED staff (not by the Ortho residents) and referred to Ortho:
ED-generated consult sheets will be forwarded daily to Orthopedics by the ED. The sheets will go to the appointment schedulers to call all patients to arrange for an appointment – using the following guidelines.
   a. "Stable non-displaced fractures" (i.e., splinted in the ED, usually not seen by Ortho) should ideally be seen at the location closest to where the patients live, preferably at a satellite, and may be seen as soon as possible by one of our sports pediatricians, if an orthopedic surgeon is not available at that site as soon as possible (i.e., within 24 hours).
      Priority of distribution, for stable and non-displaced (splinted in the ED) fractures:
         o On-call Orthopedic surgeon, if there is an opening on their schedule ASAP at a location near the patient’s home (preferably at a satellite)
            - Another available Orthopedic surgeon (operative or non-operative)
         o Patient-physician preference
            - Pediatric Sports MD - "first responders" if no orthopedic surgeon available. Ideally, the schedulers/secretaries /coordinators should try to book these appointments early in the clinic schedule; inform patients that they are "add-ons"; and instruct them to come early. Patients should be front loaded,
when possible at 7:45 or 8 a.m. They may have to wait to be seen so they should be advised to bring reading materials/games for their children, and to have their X-rays and reports ready to bring directly to the appointment.

b. **Unstable fractures, displaced fractures, and elbows** must be seen immediately by the orthopedic surgeon who was on call at time of injury, or the next available orthopedic surgeon.

**Note:** If there is any concern that the fracture is not stable and displaced, the patient should be seen by an orthopedic surgeon.

D. **Fractures from outside emergency rooms and referring physicians.**
   a. These fractures should be offered an immediate appointment.
      Priority of distribution is:
      • Doctor on call the day of the injury
      • Other available orthopedic surgeon
      • Sports Pediatricians as “first responders” if an orthopedic surgeon is not available within 24 hours.
   b. When assessing patients for possible fractures:
      • We need to continue to state that there is a possibility of growth plate fracture or non-visible “micro fracture” to the families. This should be documented.
      • Those in considerable pain should be splinted, even in the absence of a definite fracture, when appropriate.
      • Follow up should be considered/recommended, preferably with a CHOP Orthopedic attending. It should be explained that the reason for this follow up is to detect a “micro fracture” or growth plate fracture that may not be visible on plain x-rays.
      • Careful documentation is key.

2. All CHOP Orthopedic OR cases
   It is the expectation that each resident and fellow will have direct communication (contact directly or come to the office) with the attending the day before all elective cases to discuss rationale and approach for cases

3. Booking OR cases in the middle of the night
   OR Anesthesia wants to learn about add-ons one at a time, not in bulk. To book cases in the middle of the night, we should carry the add-on sheets with us, and for each add-on case, as they present themselves (not in bulk) we should:
   Booking OR cases in the middle of the night:
   a) Fill out the add on sheets and drop off at desk
   b) Speak to OR charge nurse about add on
   c) Then page anesthesia 10345

4. ER consults
   All ED patients must be seen by an ED attending. There is a Hospital policy for sedation of
patients for procedures (such as fracture reduction or PICC insertion). *You must get a signed consent (same form as for OR procedures).*

There is an Emergency Department policy allowing family members to be present in the treatment room during procedures and resuscitations, if and when appropriate.

a. The staff will:
   i. Assess the family members’ ability to handle each situation.
   ii. Explain the procedure and their role during the procedure.

b. The guidelines can be found in the blue Resident Policy Manual in the residents’ office.

**L. Clinical Fellow On-Call Policy**

**Goals**
- Enhance fellowship education and training by improving exposure to trauma cases, and providing the opportunity to function in the after-hours trauma environment where extremely efficient and effective assessment and management of pediatric injuries is required
- Provide the fellow opportunities to progress to independent function required of attending pediatric orthopedic surgeons in practice
- Provide the fellow with more opportunities to teach pediatric orthopedic surgery to younger trainees in an operating room and emergency department environment
- Improve patient care by providing ample in-hospital manpower to assess and manage pediatric orthopedic consultations during high-volume time

**Implementation**

On-call scheduling for the fellows:

- Call is distributed equally among the fellows
- Call is from home, unless called in for surgery or emergency care
- It is recommended that fellows take call from home one week a time, arranged Monday to Sunday. The schedule is set by the fellows and can be altered at their discretion.
- A printed call calendar should be distributed to the on-call attendings, including the cell phone or other contact number for the on-call fellow
- If the fellows change the call schedule, they should alert the on-call attending

Fellow on-call responsibility:

- The on-call fellow will come into the hospital (or remain in the hospital) without exception if any of the following apply:
  - There is more than one orthopedic case scheduled on a Saturday or Sunday or holiday
  - There is an orthopedic operation expected to take more than two hours (e.g. T-condylar humerus, femoral nailing, multi-trauma), or the attending on call believes the trauma case has particular educational value for the fellow
The on-call fellow will come into the hospital (or remain in the hospital) as determined by the attending and in-house resident if any of the following apply:

- High emergency department volume, combined with other service needs, as determined by the in-house resident and attending
- Any after-hours surgical case on weeknights, if there are patients in the emergency department or other inpatient orthopedic needs

It is a fellow’s responsibility to contact the operating room or the on-call resident before the start of surgery each weekend or holiday morning to determine if the criteria above are present.

The on-call fellow will participate in operating room, emergency department or floor activities at the discretion of the attending surgeon in consultation with the fellow and on-call resident.

M. Specific situations

1. (SCAN) Suspected Child Abuse and Neglect (for every SCAN admission, contact SCAN Attending on call … beeper 10697)

**Please note: notifying the SCAN social worker does not eliminate the need to contact the SCAN Attending on call.**

If you are uncertain about the need for a SCAN consult, please call the Trauma Social Worker (beeper: 10031) for assessment and triage.

Indications for a SCAN (suspected child abuse/neglect) consult:

- Any patient with obvious injuries from inflicted trauma.
- Any injured patient where there is a concern of possible child abuse:
  - No history of trauma to explain the injury
  - History does not seem consistent with the injuries sustained
  - History does not match developmental abilities of child
  - Unexpected or unexplained delay in seeking care.
- Children with injuries that resulted from domestic or family violence
- If the child has no injury, social work consult is recommended.
- Children transferred from home or outside hospitals where a report of suspected abuse was made prior to the child’s arrival at CHOP.
- Infants admitted with fractures or intracranial injury that resulted from ‘household trauma’ (in private; non-neutral witnessed locations or circumstances) should be seen by the SCAN Team.
- Injuries that occur in public locations and were witnessed by non-family members can be reviewed by social work, without the need for SCAN consult, unless concerns arise.
- Suspected cases of severe physical neglect, Munchausen Syndrome by Proxy (MSBP), injuries from sexual assault, intentional poisonings, or other situations that are concerning for possible child abuse, should be referred to the SCAN Team.
Ambulatory children who sustain single fractures with a reasonable history of trauma do not require a SCAN consult, unless concerns arise, or a report of suspected abuse was made by an outside hospital. (see #4)

Pediatricians will usually handle SCAN consults: Ortho responsible for SCAN consult if admitted to Ortho service. In general, the child will need a skeletal survey, SCAN/social work consult and CY-47.

The skeletal survey should be done prior to spica cast application.

The child should be admitted to pediatric service and must be cleared by SCAN physician before discharge.

If admitted to Ortho service, a clearance note by SCAN must be placed on the chart before discharge.

2. Trauma patients
   i. Patients with multi-system injuries (for example, loss of consciousness and fractured arm) will generally be admitted to the Trauma Service.

   ii. The disposition of all trauma admissions will be at the discretion of the Trauma Team. The Orthopedic Service will accept any patient cleared by Trauma if their main injuries are orthopedic. (Any discrepancy regarding the appropriate admitting service should be resolved at the attending level.)

   iii. Patients not admitted to Trauma Service must have the following consults/labs as per Trauma protocol:

       1. Trauma service consult
       2. Trauma social work consult for all femur fractures and any orthopedic injury in a child under 2 years of age
       3. Rehabilitation consult (unless you document in chart why it isn’t necessary)
       4. Urine tox screen (patients with penetrating trauma)

To improve “flow” for trauma patients and to eliminate delays between reduction cases, please work with the trauma RNs and the charge RN to prioritize patient care; e.g., if a patient with a non-displaced fracture is getting a cast it can be done in another room while the next conscious sedation patient is moving to the cast room.

There are trauma nurse practitioners available Monday through Friday 8 a.m. to 5 p.m. to cover issues. Beeper 19660 or 17346.

3. Hand call
   Rotates monthly among several attendings. Orthopedic residents will be called first. Hand/finger fractures need to be seen in the office within days of the ED visit. Please emphasize to the parents to call for an appointment the next business day.
4. Spine trauma
   Usually both neurosurgery and orthopedics are involved.
   - Every spinal column injury: Ortho is consulted
   - Attendings: Dormans, Drummond, Flynn, Spiegel, Baldwin, Sankar
   - Every spinal cord injury: Neurosurgery is consulted
   - For cervical spine fractures with cord injuries, neurosurgery will direct care
   - For thoracic and lumbar spine fractures with cord injuries and cervical spine fractures without cord injury, Ortho will direct care

5. SPICA Casting
   Any child placed in a SPICA Cast in the ER needs to be admitted for PT consult, for teaching, DME needs, and transportation. A SPICA car seat or an ambulance takes hours to set up

N. Surgical Specimen Collection Algorithm

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Surgical Specimen Collection Algorithm

<table>
<thead>
<tr>
<th>LAB ORDER</th>
<th>TYPE OF SPECIMEN</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>JOINT, PLEURAL, PERICARDIAL ASPIRATION FLUID</td>
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<tr>
<td></td>
<td>PURULENT MATERIAL</td>
</tr>
<tr>
<td></td>
<td>TISSUE OR BONE ASPIRATION</td>
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<td></td>
<td>HARDWARE REMOVAL</td>
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<thead>
<tr>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>SITE</td>
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<tr>
<td>Large Volume</td>
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<tr>
<td>Small Volume</td>
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<thead>
<tr>
<th>SPECIMEN CONTAINER</th>
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<tbody>
<tr>
<td>STERILE PLASTIC (URINE) CONTAINER</td>
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<td>STERILE PLASTIC (URINE) CONTAINER</td>
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<tr>
<td>STERILE PLASTIC (URINE) CONTAINER</td>
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<tr>
<td>BIG SWAB</td>
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<tr>
<td>DOUBLE TIP SWAB</td>
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<tr>
<td>STERILE PLASTIC (URINE) CONTAINER</td>
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<table>
<thead>
<tr>
<th>VOLUME</th>
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<tbody>
<tr>
<td>AS MUCH AS POSSIBLE; IDEALLY GREATER THAN 0.5ml</td>
</tr>
<tr>
<td>SEND AS MUCH SPECIMEN AS POSSIBLE</td>
</tr>
<tr>
<td>AS MUCH AS POSSIBLE; AT LEAST A SIMILAR SIZE AS PATHOLOGY SPECIMEN</td>
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</table>

| ADDITIONAL INFO |
|-----------------
| Clinical staff should NEVER inoculate specimen fluids other than blood into blood culture bottles. ONLY MICROBIOLOGY Lab technicians will inoculate blood culture bottles with JOINT, PLEURAL, OR PERICARDIAL FLUID. It is greater than 0.5ml in the sterile container. This technique allows for continuous monitoring and improved yield. |
| Add Fungal or AFB/MYCObacterial culture for tissue & bone aspirates when clinically indicated. |
| Fungal & AFB/MYCObacterial cultures need large tissue samples. |
| Use GRAY ANAEROBIC tubes for anaerobes immediately after specimen collection, when clinically indicated. |
| Bone Marrow aspirates are best collected in YELLOW SOLUTOR tubes (call Micro Lab to obtain). |

<table>
<thead>
<tr>
<th>TRANSPORT</th>
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<tbody>
<tr>
<td>After verifying specimen orders, TIGHTLY close &amp; send via PNEUMATIC TUBES OR HAND-CARRY (if glass) to Clinical Microbiology Lab. DO NOT REFRIGERATE—it kills organisms!</td>
</tr>
</tbody>
</table>

FOR QUESTIONS, call Clinical Microbiology Lab x42330 (open 24/7) |
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O. Inpatient Units

Sign off from the off-call resident to on-call resident is patient to patient rounding not just “running the list”. Beeper 14945 for all orthopedic patient floor issues 24/7. From 8:30 a.m.-4 p.m. Monday through Friday, rounds beeper 14945 is covered by a nurse practitioner. After sign out, all calls will be forwarded to 11014. Beeper 11014 is for OR, ER, and consults. Direct all floor calls to 14945.

After sign-out, the inpatient nurse is usually available in the Division of Orthopedic Surgery for questions.

1. Rounds
   The on-call resident will:
   a. Speak with attending at or after morning conference on every patient to receive plan of care
   b. Write a clear, brief plan with the words “discussed and approved by attending” and list that attending’s name clearly. Attending surgeons will see the patient each day to sign or amend the documented plan. If progress note templates are used make sure the date is changed daily. Progress notes are in Orthopedic Department on shelving unit next to the copy machine.
   c. Round with the patient charge nurse of 4E/4S and nurse practitioner and physical therapist to review plans of care and census management.
   d. Accompany clinical fellows on post-op rounds.
   e. Round with weekend/holiday attending and charge nurse.

2. Standard Order Sets in EPIC
   a. Altered mobility
   b. Surgical limited admit
   c. ACL reconstruction
   d. Admission
   e. Cervical injury/halo
   f. Common radiology
   g. CP/VDRO
   h. Discharge
   i. DDH
   j. Excision/biopsy
   k. Ex Fix/osteotomy
   l. Femur fracture
   m. Knee arthroscopy
   n. Post-Op PSF
   o. Post-Op short stay
   p. SCFE
   q. Supracondylar fracture

3. Nurses
   **4East/4South Resident Orientation**
   The following are tips and guidelines for making your rotation on our pediatric surgical floor easier:
   o Patient assignment sheets are located at the nurses’ station. In addition, each nurse has his or her own Ascom phone and can be called directly if needed.
○ There is a charge nurse designated for each shift. She will have the most updated information regarding admissions from the ED, post-ops, and transfers.

○ The best way to communicate changes in the plan of care is to speak with the nurse directly. This is especially important when putting in NOW or STAT orders, ordering new medications, or any other important changes in the plan of care. If the nurse is not available for updates about the patient, please give the information to the charge nurse.

○ If you were in the OR with a particular patient, when doing your post-op check, any helpful information you can give the patient’s nurse is appreciated. Things such as expected post-op findings that may be out of the ordinary, specific procedures in the OR, etc. are particularly useful in guiding our nursing care.

○ When rounding in the early morning, consider waking the parents if asleep. If in doubt, ask the nurse. This may decrease questions and pages throughout the day.

○ Whenever possible, painful procedures should not be done at the bedside. Instead, the child should be brought to the treatment room. Inform the nurse as soon as possible so that the child can be premedicated and Child Life can get involved. No child should have a painful procedure without being properly medicated.

Emergency situations

○ CHOP has implemented a program to help decrease the incidence of codes outside of the ICU setting. To that end, each patient receives a Modified Pediatric Early Warning Score (MPEWS) with each set of vital signs. The score corresponds to a category, which corresponds to a level of response. When a patient reaches a certain score, or has concerning changes in respiratory, cardiovascular, or neurological status, or the parents or nurse have a “gut feeling” that the patient does not look right, the Critical Assessment Team (CAT team) will be called. If this happens, the nurse will notify you as the service of record. Your responsibility will be to come to the bedside to meet the CAT team (which arrives within 30 minutes of the call) and be a resource to them. They make recommendations about patient treatments and make a plan for follow up, whether that means transfer to the ICU, or to remain on the unit with close monitoring. You will be responsible for order entry and follow-up if needed.

Tips for entering orders

○ When ordering labs, please be aware of the scheduled lab draw times: 0600, 1100, 1500, and 2000. Orders need to be entered at least an hour before the next lab draw. If stat labs are needed, you may have to personally draw the lab.

○ To ensure that the phlebotomist draws the labs at the scheduled time, the order needs to read “Scheduled for Phlebotomy” and have the specified time.
- TPN orders need to be renewed by 1100 at the latest; new TPN orders need to be entered by 1300 at the latest.
- Consents for procedures or surgery need to be obtained prior to the scheduled date or the surgery will be delayed.
- Procedures requiring sedation need to have proper orders entered or the procedure will be delayed. Be sure to contact the Sedation Service for a patient work up.
- When consulting additional services, an EPIC order and phone call to the service are required. PT/OT/Speech consults only need an EPIC order.

**SkyTel downtime paging procedures**
- Occasionally, the SkyTel pagers will stop working or malfunction. When this happens, you may hear an overhead page announcing the “downtime,” and it will be posted on the home page of the CHOP Intranet. Please obtain the downtime cell phone in your call room on the 9th floor. Once the downtime is over, please return the cell phone to your call room.

**Family centered care practices**
- Please remember that you are not just working with the patient, but with the family as well. Always include the child in decision-making and the plan of care when possible.
- Please also remember to clean your hands before and after your interactions with patients and families. As you know, hand hygiene is the #1 (and easiest) way to help prevent the spread of infection. There are Purell dispensers outside of every room on 4East and 4South, as well as at the patients’ bedsides. Each room also has a sink as you walk through the door. If your hands are not visibly soiled, you may use the alcohol hand rub.
- Please remember your five moments of hand hygiene:
  - Before touching a patient
  - Before clean/aseptic procedure
  - After body fluid exposure risk
  - After touching a patient
  - After touching patient surroundings
- You should use alcohol hand rub in all patient care except when:
  - Hands look or feel soiled
  - Caring for a patient experiencing vomiting and/or diarrhea
  - Direct hand contact with any body fluids occurs and gloves have not been worn
  - Caring for patients during outbreaks of GI illnesses such as Norovirus, C. Diff, or any other diarrheal illnesses
  - After using a bathroom
- Our goal is to have 100 percent compliance with hand hygiene at all times.
4. Pharmacy Orders

Pediatric standards and dosing are very different than adults.

a. EPIC drug order entry system is designed to help you with correct and complete orders
b. Avoid typing in orders that bypass the safety nets of the system
c. Pharmacists review ALL orders for potential or actual errors
d. Contact a pharmacist to ask questions at ext. 4-1899 or 4-1894
e. When a pharmacist contacts you with questions respond in the appropriate manner to someone concerned with our patient’s safety in preventing medication errors

5. Pain Management

a. IM injections are not used.
b. Codeine is no longer available at CHOP, percocet is not in formulary
c. Pain Management service manages PCAs
   - Usually consulted for “major” cases post-operatively. They will write orders, adjust dosages of PCA, etc. Do not order pain meds or valium for patients managed by Pain Team.
   - If Pain Team is consulted, changes in pain management are done only by them. If we have concerns about management, Pain Team to discuss. Beeper 10444
   - Single injection intrathecal morphine given in OR
     1. NO IV OPIOIDS for 12 hours unless ordered by Pain Management Team
     2. Nalbuphine rescues only for first 12 hours
d. Morphine sulfate (.05 mg/kg per dose) should be written as IVSS – not IV push, unless you want to administer it. Nurses cannot give morphine sulfate IV push.
e. On-Q “silver soaker” catheter – for local wound infiltration for VEPTRs.
   Pain service must be notified of patient and solution needed the day before surgery. This is to be hooked up intraoperatively by Ortho.
f. Never pull pain control device because it appears to be non-functioning. Check placement, reposition, etc.
g. Peripheral nerve catheters go home with patients. The pain team manages these.
h. When ordering post-op narcotic, EPIC, defaults to every 6 hours-please scroll up to every 4 hours.

P. Integrated Care Service

4W CSH (CHOP General PEDS)

The Integrated Care Service is a team of physicians, nurses, social workers, case managers and other providers who have specific interest and expertise in improving outcomes for hospitalized children with complex chronic conditions. The team emphasizes continuity, close working relationships with consultants, and the integral role of the family in patient care. The service is especially appropriate for a child requiring the inpatient services of CHOP sub-specialists or surgeons, but who also would benefit from
a team dedicated to the oversight of complex medical issues. If you are interested in having us set up a transfer or an admission for such a patient, contact Allison Ballantine.

Considerate Conduct
Be aware that children and parents admitted to the Hospital find themselves in a foreign environment often under difficult and stressful circumstances. As professionals, it is our responsibility to:

1. Identify ourselves and the team we represent each time we enter a room
2. Be mindful of developmental differences in children and treat them accordingly — pediatric patients are not small adults.
3. Do NOT discuss information in front of visitors without the parents’ permission for the sake of privacy.

Q. Guidelines for Cerebral Palsy Clinic

1. The Cerebral Palsy Program is an interdisciplinary specialty clinic conducted simultaneously alongside Dr. Flynn’s general pediatric orthopedic Tuesday morning clinic on the second floor of the Wood Center. Each week, between five to 15 children with cerebral palsy will arrive for a musculoskeletal evaluation.
2. Each week the chief resident must assign one resident to cover CP clinic. Each of the residents is expected to read the chapter on cerebral palsy and the chapter on gait in the 5th edition of Lovell and Winter.
3. A new patient’s history should include perinatal history, developmental milestones, any prior orthopedic treatments and parental concerns of orthopedic issues. For follow-up patients, the history should focus on the child’s age, level of involvement, function and current problems. On examinations, you should watch the child walk with and without their braces and carefully record their range of motion on orthopedic data sheets. We use the joint ranges of motion on these data sheets to define the patient’s problems, monitor their contractures, plan operations and measure outcome.
4. For spastic hip disease, we order an AP supine X-ray and measure Reimer’s Migration Index. Scoliosis is followed with sitting or standing radiographs and measuring the Cobb angle.
5. On the door of each patient’s room will be a summary form that we use to communicate each of the doctor’s or therapist’s recommendations. These recommendations are summarized in a letter. It is very important, for communication purposes, to write our essential findings and recommendations on these communication sheets so that they can follow the patient down to the clinic.

R. Office Procedures

1. Presence
   All residents and fellows not in the OR must be present. “On-call” resident should assist with office hours when not busy with call activities.

2. Clinic Attendance Policy:
   i. **Expectations:** Experience in the outpatient clinics is an essential component to well-rounded resident and fellow education. It is expected
that both residents and fellows should spend at least \( \frac{1}{2} \) day, and preferably 1 day, per week in the outpatient clinic setting. For a resident on a 3 month rotation at CHOP this amounts to a minimum of 12 half days.

ii. **Designation of clinical duties:** In order to facilitate and encourage time in clinic, a designation for the intended duties for all available residents and fellows will be agreed upon by Friday of the preceding week. Depending on the case load, the case complexity, and the number of available fellows and residents, the fellows will determine the available assignments for each day of the week. Priority will be given, as is detailed elsewhere in the handbook, to coverage of operative cases, followed by designated add-on trauma coverage, followed by clinic coverage. Per usual practice, this list of daily available clinical duties will be circulated the week before. With one pick at a time and in revolving order from fellows, to chief residents, to junior residents, daily assignments will then picked. Residents and fellows assigned to add-on trauma are expected in clinic if no add-on cases are running. In addition, with current level of NP support for floor activities, the on-call resident is expected to be in clinic for at least the morning session (before the emergency room calls begin) unless there are active floor issues that require a resident’s attention.

iii. **Tracking of clinic time:** The resident and fellows must obtain an attending signature for each clinic session. Each resident will be required to participate in clinic a minimum of 15 half-days per three month rotation and thus must collect a minimum of 15 signatures. For Fellows since the fellowship is for 12 months and we have the goal of meeting and evaluating progress at 4 month intervals, we would like to make sure there are 16 sessions recorded at 4 and at 8 month meeting. The resident and fellow may be pulled from clinic to cover add-on cases at the add-on Attending’s discretion. If the resident is pulled from clinic to cover add-on cases, the resident and fellow may obtain the operating Attending’s signature in place of the clinic Attending’s signature. Resident and fellow clinic/office logs will be reviewed at midyear and year end meetings.
### Clinic Attendance Policy:

#### Expectations:
Experience in the outpatient clinics is an essential component to well-rounded resident and fellow education. It is expected that both residents and fellows should spend at least 1/2 day, and preferably 1 day, per week in the outpatient clinic setting. For a resident on a 3 month rotation at CHOP this amounts to a minimum of 15 half days.

**Designation of Clinical Duties:** In order to facilitate and encourage time in clinic, a designation for the intended duties for all available residents and fellows will be agreed upon by Friday of the preceding week. Depending on the case load, the case complexity, and the number of available fellows and residents, the fellows will determine the available assignments for each day of the week. Priority will be given, as is detailed elsewhere in the handbook, to coverage of operative cases, followed by designated add-on trauma coverage, followed by clinic coverage. Per usual practice, this list of daily available clinical duties will be circulated the week before. With one pick at a time and in revolving order from fellows, to chief residents, to junior residents, daily assignments will then picked. Residents and fellows assigned to add-on trauma are expected in clinic if no add-on cases are running.

**Tracking of Clinic Time:** The resident must obtain an attending signature for each clinic session. Each resident will be required to participate in clinic a minimum of 15 half-days per three month rotation and thus must collect a minimum of 15 signatures. The resident may be pulled from clinic to cover add-on cases at the attending’s discretion. If the resident is pulled from clinic to cover add-on cases, the resident may obtain the operating attending’s signature in place of the clinic attending’s signature. Fellows are required to participate in 48 sessions.

### Clinic Attendance

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Revised 6.16.2011

### 3. Office Protocol

a. The primary goal of resident and fellow clinic attendance is educational. The resident and fellow will be asked to dictate and utilize EPIC at the attending’s discretion in situations that require assistance with clinic flow. It is expected that participation in clinic will be graded based on experience, and progress from a “shadowing” type of learning experience to one of more independent evaluation with time and experience with each individual attending.

b. Please problem-solve during office hours. Be on the lookout for patients who are put into a room without having had appropriate X-rays done. Intercept these patients and get them to X-ray rather than having them wait for a long time only to be told that they need an X-ray.

c. When the attending is busy, see at least two patients and be ready to present when the attending arrives. Priority is to be given either by order of arrival or to quick patients (i.e., fracture follow-ups) first so that the attending does not get caught in a room with a difficult patient, while quick patients wait. Give preference to those who have been waiting.

d. You should try to provide consistent care during an office visit. For example, if you see the patient and send him/her to X-ray, you should see the patient when he/she returns from X-ray.
e. You should complete the EPIC note which serves as the letter to the primary care physician with copies to the family, physical therapist or other specialists involved.

f. Be sure in your dictation to identify the attending that saw and was involved in the care and evaluation and treatment plan. For example, the wording should be “Dr. Davidson’s plan after history, examination and review of records was to...” Do not say “The patient was seen by Dr. Davidson.”

g. Be courteous to all patients.

h. Do NOT see a patient and subsequently leave the area (i.e., going to surgery or to take care of a problem on the floor) without discussing the patient with an attending or transferring the patient to another NP/PA to present to the attending.

i. All patients are to be seen by an attending. If for some reason the attending cannot see the patient, the patient cannot be billed.

j. Be sure to have new patient sheets completed by the family and verified by you with the patient. If you have never seen the patient before, they are a new patient for you and you should go through a complete history and pertinent PE (especially if the patient is a complicated patient). All handwritten notes should be made on the new patient form or on the follow-up patient form. These forms should be signed by the attending. We rely on these handwritten notes if the patient is seen again before the dictation is transcribed.

k. The format for dictation should be diagnosis, date of injury (if applicable, history, physical exam, radiographs, labs, etc.), and plan. The problem oriented approach to assessment is used in listing problems numerically in the assessment and treatment section. This is useful for children with neuromuscular problems such as cerebral palsy.

l. In the front of the chart is a green sheet which requires that diagnoses, treatments and interventions be listed. The date of injury should be listed for all fractures. This is a JCAHO requirement and should be completed on all patients.

m. Pain assessment must be documented on all patients.

n. A service report is completed by the attending for each patient. On the bottom right-hand side of the service report, write what X-rays will be needed, as well as cast room needs for the next visit and when the patient should return for follow-up. The completed service report is sent with the patient to the discharge desk.

o. Have all appropriate X-rays on the computer before presentation to the attending. Make sure you have all pertinent and necessary lab work and test results available before presentation to the attending. This includes MRI, CT scan or bone scan results and any pertinent laboratory values.

p. Make sure all patients have a complete and pertinent exam. For example, if a patient is presenting with a hip or back problem, make sure that they are in a patient gown and appropriately undressed and gowned for the complete exam. Avoid doing an examination and having the patient get dressed again before seeing the attending.
q. When social issues are present, the clinic nurse is available to provide assistance. This is especially appropriate if compliance and cooperation are questioned. It may be appropriate to get a social worker and/or SCAN (Suspected Child Abuse and Neglect) consult.

4. Dictaphones
   Available from Ellen Denver. Use one Dictaphone per physician i.e. if seeing patients with JMF in am, must get a different Dictaphone for BDH in pm.

5. X-ray request
   Fill out an X-ray request when you are dictating. This will help the nurse/coordinator avoid filling out X-rays requests the night before office hours.

6. Surgery Scheduling
   a. Fill out pre-admission form (orange or green), including procedure (CPT) code. Attending should sign consent form with family
   b. Complete the history and physical forms - make sure consent is signed to avoid having the on-call resident called for consent on the day of surgery. Attach the unsigned, completed post-op pain prescription with name and dose to consent form.
   c. Take completed forms, patient’s chart and patient/family to the surgery coordinators (Maria Tanczak/Raquel Taylor/Tammy Solivan/Gina Hunt/Sunny Pembleton).

7. Cast Room
   a. Residents are responsible for putting on casts for their patients after proper instruction. Ortho techs (Joe Monteleone/Elizabeth Robinson/Mary Cuthbert/ Leroy White) will assist.
   b. Medical students may cast only:
      ▪ After formal instruction
      ▪ Under supervision of resident or attending
   c. Fill out white slip on front of patient chart for cast room.

8. Specific situations
   a. Sending patient to outpatient physical therapy from the office
      ▪ Fill out prescription for physical therapy in EPIC.
      ▪ Please be specific about weight-bearing status, any limitations or restrictions.
      ▪ You can send patients next door to Children’s Seashore House to make an appointment or instruct the family to contact their local hospital/pediatrician for referral in their community. (HMO patients should contact their primary care physician for referral.)
   b. School notes
      ▪ Please be as specific as possible (including date) about when child can return to school.
      ▪ List any restrictions or limitations.
Child in long leg cast may or may not be able to return to school, depending on which school he/she attends. Do not automatically assume child will get homebound tutoring.

c. Brace Shop (NOPCO)
   - The shop provides prosthetics, orthotics, abduction pillows and shoe lifts.
   - Complete appliance prescription form and letter of medical necessity.
   - Not all insurance companies have contracts with NOPCO, families may need to go to another provider.

S. Children’s Seashore House

1. The Orthopedic Fellow
   a. Covers the patients in the REHAB portion of the Seashore House (3 West).
   b. Meets with NPs in the nurse practitioner office weekly at 7:30 a.m. to review patients with orthopedic issues.

2. Residents responsible to cover:
   a. Consults on the CHOP INPATIENT portion of the Seashore House (3E & 4W).
   b. Questions/problems after hours and on weekends. Let the fellow know if events you cover occur during off-hours.

3. To go to OR from CSSH, consent form and consent for transfer must be completed before the day of surgery.

4. Discharge (transfer) to CSSH - discharge paperwork needs to be done.
   a. Child must arrive by 1 p.m. Only orthopedic cases are accepted on weekends (usually cases referred pre-op).
      - Chart must be copied and sent over – clerk will copy chart
      - Ortho writes a “Note in Progress Record” with weight-bearing status, precautions, etc.
   b. As of 7-1-03 CHOP pediatric residents no longer cover the physiatry ward (3W/Rehab) at Children's Seashore House. All patients must be medically stable at the time of their proposed admission to the ward. Before accepting any patient, the attending physiatrist will need to verify the following:
      c. Recently extubated patients must have a stable airway for at least 24 hours
      d. Children with tracheostomies must have had an initial change of the airway tube
      e. No increase in O2 requirement for at least 24 hours prior to admission
      f. Afebrile for at least 24 hours prior to admission
      g. Stable blood pressure without pressors for 48 hours (no acute intervention)
      h. No worsening in neurological status/exam in last 24 hours
      i. No increase in seizure activity in 72 hours prior to admission
j. No metabolic acidosis, electrolyte disturbance or hypoglycemia
k. Diabetes: no ketoacidosis and good glucose control for one week before admission
l. Analgesia: no requirement for epidural infusion

T. Consults
1. Same day service is required for consults to Orthopedics (including Children’s Seashore House consults). Please complete an office new-patient form for all consults.
   a. Consult should be discussed with attending as soon as possible. Attending needs to sign consult or document in progress notes within 24 hours of request.
   b. Completed consults: top copy stays on the chart, white copy to Orthopedics for filing with completed new-patient form.
2. Consulting other services -- phone call more important than order in EPIC.
   a. Attending needs to sign consult request sheet or document request for consult in progress notes within 24 hours of request.
   b. Pediatrics - general pediatrics consult beeper 14468 (super senior)
      ▪ General Pediatrics Consult: If you have any questions regarding the non-orthopedic care of a hospitalized child, they can help. You should call for both routine problems (e.g., asthma or other respiratory problem, fever of unknown source, suspected ear infections, urinary tract infections) and complex situations (e.g., complex children with multiple needs, problems where you are unsure of whom to call). The primary contact will be a pediatric resident with attending backup. Please order the consult in EPIC and call super senior.
      ▪ You should contact the pediatrician when requesting the consult. Nurses should not be told to contact the consultant.
   c. Consult Etiquette: If we are the consultant, please communicate recommendations with the primary team before changes/interventions.
3. Consults to PT/OT
   a. Inpatients:
      ▪ Nearly all patients need a PT consult. For example, kids in spicas need PT consult for transfers. OT consult needed for ADLs depending on age of child.
      ▪ Be specific as to weight bearing status and urgency of consult (prior to discharge today, within 24 hours, greater than 24 hours).
      ▪ CPM Machine - place order in EPIC with parameters, when to begin and the schedule. For home CPM write same on prescription. Remember to place PT consult within 24 hours for crutch training. If needed in OR, call beeper 15191 or the PT gym at ext. 4-1902 or 4-5819.
   b. Information for New Ortho Residents Related to Physical Therapy
      ▪ Physical Therapist who is covering orthopedics wears the beeper #15220 (regardless of who it is)
- Weight bearing status needs to be the same in all communication: EPIC orders, PT consult/request AND daily notes in chart. Having matching orders will save the on call person from multiple pages to clarify the WB status.
- “Four Point Gait” needs to be put in with “WBAT-with four point gait” as the WB status. We cannot guarantee that the patient will remain PWB with four point gait.
- For Day Surgery Patients:
  - If patient was pre-operatively crutch trained and the patient/family feel comfortable, they do NOT need a PT consult.
  - If a patient ONLY needs crutches, but not gait training/crutch training, PACU team can get crutches from SPD/OMS and patient does NOT need a PT consult.
- “Prior to Discharge” means that the patient must see PT before going home THAT day. If they are staying overnight, then it should say “within 24 hours.”
- Outpatients: complete consult sheet or prescription. Consults should contain diagnosis, any precautions/restrictions/WB status. Family can make appointments at Seashore House or seek local therapist. HMO patients should contact their primary care physician for referral to a participating provider.

4. Consults to Brace Shop (NOPCO)
   a. For prosthetics, orthotics, abduction pillows or shoe lifts
   b. Inpatients: Complete appliance prescription form and call NOPCO at ext. 4-7701 (Chris Nelson). No order in EPIC.
   c. Outpatients: Complete appliance prescription form. HMO patients should contact their primary care physician for a referral to a participating provider.

U. Scheduling an Orthopedic Patient for Sedation
   On 3W Tower Sedation Unit Physician Responsibilities:

1. Call 3W and schedule patient with charge nurse (ext. 57300)
2. When calling to schedule an inpatient info needed:
   a. Patient’s name and age
   b. Room number and unit
   c. Physician who will be doing the procedure and their beeper number
   d. The procedure to be done

3. Call the sedation team to order meds and complete pre-sedation form (Beeper 11733). Sedation unit team does not notify sedation. Orthopedics gets consent for orthopedic procedures.

4. If doing a casting or pin removal, bring all necessary equipment with you. If it is a dressing change, let us know what is needed and it will be available when you arrive to do the procedure.
5. If scheduling an outpatient for a procedure:
   a. The above directions apply with a few additions.
   b. We will need the patient's home phone number so we can call them the night before with arrival and NPO times.
   c. All insurance info needs to be taken care of prior to the day of the procedure by the surgery schedule. If a patient arrives and the insurance info is not complete we cannot do the procedure.
   d. The 3E nurse practitioner will see all outpatients and complete all paperwork. A physician just needs to co-sign. Sedation orders are placed on the pre-sedation assessment form since there is no outpatient screen in EPIC for orders.

6. NPO Times:
   a. Zero to five months of age - four hours for solids, two hours for clears, and three hours for breast milk
   b. Zero to 36 months of age – six hours for solids, two hours for clears and three hours for breast milk
   c. Patients older than 36 months of age – eight hours for solids, two hours for clears and three hours for breast milk

V. CVS Outpatient Pharmacy
215-823-6993

Prescription writing. All written scripts should include the following information:
1. Patient’s:
   • Name
   • Current weight
   • Birthdate
   • Diagnosis

2. Name of medication- Remember written prescription must be same dose as in EPIC.
   • Concentration of the liquid strength of tablet
   • Dose in mg (not mLs) to be administered
   • Frequency
   • Volume dispensed or quantity of tablets
   • Number of refills

3. Physician name – printed and signed
   • M.D. license number, NPI number
   • D.E.A. number
   • Beeper number (to contact for questions about dose or insurance issues)

   Prescription plans require diagnosis when pharmacist calls for an override.
**Controlled Substance**

1. The pharmacist cannot alter controlled substance prescriptions by law
2. The prescription must have the:
   - Quantity of tablets or
   - Volume of solution to be dispensed
   - Write: number of tablets and number of mLs

   1. Do not write: 1 tablet BID x 10 doses
      5 mL TID x 5 days

**W. Policies to be aware of**

1. **HIV Testing**: Must get written consent from parent or legal guardian for HIV testing. Counseling must be provided (and documented), regardless of test results. Resource: Staff from Special Immunology Clinic.
2. **Sedation**: Must get written consent for parent or legal guardian when giving child sedation for procedures. Child must be monitored during the procedure and while recovering from sedation.
3. **Latex allergies**: Patient with known or suspected latex allergies must be placed on “latex precautions” and pre-medicated before surgical procedures. Patients at risk: spina bifida and CP patients with shunts and/or previous surgeries. Standard orders on TDS: Ordering Guide on the lower right-hand corner of screen.
4. **Treatment for IV infiltrates or occlusions**: Line evaluated by IV Team who will make recommendations for management: Ortho will need to write orders.
5. **Restraint during acute medical-surgical care**: MD order and reassessment necessary.

**X. Evaluation of Rotation**

At the end of the rotation, please:

1. Fill out an evaluation of the rotation (the form will be distributed by Dr. Dormans' secretary).
2. Turn in your OR log - Print a copy of your log from the Web site and bring with you to the exit interview.

**PER ACGME GUIDELINES**: *What should be reported?* All Orthopedic Surgery residents in their PGY-2 through PGY-5 years must report operative procedures and manipulations for which they were resident surgeons or assistants. Procedures which residents observe should not be reported.

All operative procedures and manipulations, in the operating room, emergency room, or any other venue, must be reported.

In rare circumstances, cases will involve more than five CPT Codes. Residents who perform such a procedure should select and report only five CPT Codes.

CPT Codes must be entered in accordance with the guidelines in the most recent *Complete Global Service Data for Orthopedic Surgery* (published by the
American Academy of Orthopedic Surgeons) and most recent *Current Procedural Terminology* (published by the American Medical Association).

Fellows and residents should discuss the coding with the attending surgeon at the end of each case to insure correct coding per ACGME guidelines.

3. Make an appointment for your exit interview with Dr. Dormans.

**Additional policies, procedures, service guidelines and other support materials will be provided to residents and fellows on-site.**